UTAH DEPARTMENT OF HEALTH PRIOR AUTHORIZATION REQUEST FORM

LUXIQ FOAM (betamethasone valerate)

Patient name:_____Medicaid or SS#_____
Physician Name:_____ Contact person:_____
Phone#:_____Ext. and options_____Fax#_____
Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

DOCUMENTED failure on generic formulations of betamethasone valerate creams or ointments within the last 12 months.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy

7/10/6